Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4812 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PETERSON REGIONAL MEDICAL CENTER
551 HILL COUNTRY DR
KERVILLE, TX 78028

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-11-0736-01

MFDR Date Received
NOVEMBER 5, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Denied for 95 day limit proof of timely filing through P2P Link enclosed."

Amount in Dispute: $1,528.75

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor has not been able to reasonably establish an actual date the bill was mailed, faxed, or electronically submitted to Texas Mutual."

Response Submitted by: Texas Mutual Insurance Co, 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 24, 2010	72148, 73510	$1,528.75	$705.81

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement of Workers' Compensation Professional Services provided on or after March 1, 2008.
4. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
5. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
6. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.

7. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 2, 2010
   - CAC – 29 – The time limit for filing has expired.
   - 731 – Per 133.20 provider shall not submit a medical bill later than the 95th day after the date the service for services on or after 9/1/05

   Explanation of benefits dated October 13, 2010
   - CAC – W4 – No additional reimbursement allowed after review of appeal/reconsideration.
   - CAC – 29 – The time limit for filing has expired.
   - 731 – Per 133.20 Provider shall not submit a medical bill later than the 95th day after the date the service, for services on or after 9/1/05
   - 891 – No additional payment after reconsideration

Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with Texas Labor Code § 408.027and 28 Texas Administrative Code § 102.4
3. Is the requestor entitled to reimbursement for services rendered?

Findings

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.
2. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." A review of the requestor's submitted documentation finds a copy of a Bill Information page and a Turn Around Time Report from P2P link which shows that the disputed bill was submitted to payer on May 10, 2010.
3. The requestor submitted a medical bill to the respondent within 95 days from the date the services were rendered in accordance with Texas Labor Code § 408.027. Therefore, reimbursement is recommended in accordance with 28 Texas Administrative Code § 134.203 as follows.

   CPT Code 72148: 54.32 WC CF/36.0791 Medicare CF x 434.62 Participating amount = $654.36

   CPT Code 73510: 54.32 WC CF/36.0791 Medicare CF x 34.17 Participating amount = $51.45

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $705.81.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $705.81 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	1/11/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.